

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6149

**63-044125**  
STATE FILE NUMBER

**FILED DEC - 2 1963**

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>JACKSON</u>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>ILLINOIS</u> b. COUNTY <u>WINNEBAGO</u>                         |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>KANSAS CITY</u>  |   | c. CITY OR TOWN <u>ROCKFORD</u>  |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>ST. MARY'S HOSPITAL</u>  |   | d. STREET ADDRESS (If outside, give location)<br><u>613 9TH STREET</u>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>ELIS</u> Middle <u>M.</u> Last <u>MATTSON</u>  |   | 4. DATE OF DEATH<br>Month <u>NOVEMBER</u> Day <u>12</u> Year <u>1963</u>   |   |
| 5. SEX<br><u>MALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>          | 8. DATE OF BIRTH<br><u>3/5/1924</u>                                       |
| 9. AGE (last birthday)<br><u>39</u>  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>REPRESENTATIVE</u> |  | 11. BIRTHPLACE (City and state or country)<br><u>ROCKFORD, ILLINOIS</u>   |
| 10a. FATHER'S NAME<br><u>MICHAEL MATSON</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>SALES</u>  |   |
| 13a. FATHER'S NAME<br><u>MICHAEL MATSON</u>  |   | 13b. MOTHER'S MAIDEN NAME<br><u>MINA</u>   |   |
| 14. NAME OF HUSBAND-OR WIFE<br><u>ARLENE MATTON</u>  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of serv)   |   |
| 16. SOCIAL SECURITY NO.<br><u>[REDACTED]</u>   |   | 17. INFORMANT<br><u>MRS. ARLENE MATTON, ROCKFORD, ILLINOIS</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Spontaneous Subarachnoid Hemorrhage</u><br>DUE TO (b) <u>Ruptured Aneurysm Rt. Mid. Cerebral Artery</u><br>DUE TO (c) <u>4 DAYS</u> |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 DAYS</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.)   |   |
| 20c. TIME OF INJURY<br>Hour <u>6:40 A.</u> Month, Day, Year <u>7 NOV 1963</u>  | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>              |  |   |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   | 20f. CITY, TOWN, OR LOCATION<br><u>ROCKFORD</u>   |  |   |
| 21. I attended the deceased from <u>7 NOV 1963</u> to <u>12 NOV 63</u> and last saw him alive on <u>11 NOV 1963</u><br>Death occurred at <u>6:40 A.</u> on the date stated above, and to the best of my knowledge, from the causes stated.       |   | 22c. DATE SIGNED<br><u>12 NOV 63</u>   |   |
| 22a. SIGNATURE<br><u>Paul J. Gentner MD</u>  |   | 22b. ADDRESS<br><u>2727 Main St. Kansas City Mo.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>REMOVAL</u>  | 23b. DATE<br><u>NOV. 12, 1963</u>   | 23c. NAME OF CEMETERY OR-CREMATORY<br><u>SCANDINAVIAN CEMETERY</u>   | 23d. LOCATION (City, town, or county) (State)<br><u>ROCKFORD ILLINOIS</u> |
| 24. FUNERAL DIRECTOR<br><u>D.W. NEWCOMER'S SONS</u>  |   | 25. DATE RECD. BY LOCAL REG.<br><u>11-12-63</u>  | 26. REGISTRAR'S SIGNATURE<br><u>Bessie Smith</u>                          |

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

Paul J. Gentner

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

Dr. Paul J. Centon  
2727 Main Street  
10:30. 5:00

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.